CHAPTER V

BILLING INSTRUCTIONS

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CHAPTER V
BILLING INSTRUCTIONS

INTRODUCTION

The purpose of this chapter is to explain the procedures for billing the Department of Medical Assistance Services (DMAS) for assisted living. Billing procedures for both levels are identical except for the procedure codes used to identify the type of service rendered.

Two major areas are covered in this chapter:

- **General Information:** This is information about reimbursement rates, submission of invoices, timely filing of claims, claims inquiries, and billing supply procedures.

- **Billing Procedures:** Instructions are provided on the completion of the claim form and the submission of adjustment requests.

RATES OF REIMBURSEMENT FOR ASSISTED LIVING SERVICES

For any assisted living facility (ALF) that is licensed by VDSS as an assisted living facility and that has contracted with DMAS as an assisted living provider, DMAS will reimburse a per diem fee for each individual who is authorized for assisted living services. Payment of the per diem fee is limited to the days in which the recipient is physically present in the facility. The reimbursement rate is considered by DMAS as payment in full for all administrative overhead and other administrative costs that the assisted living facility incurs. Only whole days can be billed. Providers may only bill for services one time each month per eligible recipient.

Regular Assisted Living Services

Regular assisted living services are defined as services provided by licensed ALFs to persons who have dependencies in two activities of daily living (ADLs) or are dependent in behavior, but who do not meet the criteria for intensive assisted living. Coverage is provided under a state-funded program for individuals who have been determined to require regular assisted living services. It provides the ALF with a per diem reimbursement of $3.00 per day (not to exceed $90 monthly), in addition to the Auxiliary Grant (AG) or General Relief (GR) payment. The facility must provide hands-on assistance or supervision with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) and other service(s) as identified on the resident's Individualized Service Plan (ISP).

The CPT/HCPCS procedure code (Locator 24D on the CMS-1500 (12-90) invoice) to bill DMAS for regular assisted living services is T1020.

Intensive Assisted Living Services

Intensive assisted living services are defined as services provided to persons who have dependencies in at least four ADLs, or who have a combination of dependencies in two or more ADLs and are rated as semi-dependent or dependent in a combination of behavior and orientation. Payments for intensive assisted living services are made from state funds. The program is targeted to persons whom the state can determine would be at risk of institutional placement if services offered were not available. This program provides the ALF with a per diem reimbursement of $6.00 per day (not to exceed $180 monthly), in addition to the AG payment, for coverage of the assistance with activities of daily living that these individuals require to avoid the risk of nursing home placement. This policy only applies to those in intensive assisted living (IAL) on or before March 17, 2000.

The CPT/HCPCS procedure code (Locator 24D) on the CMS-1500 (12-90) invoice to bill DMAS for intensive assisted living services is T1020, with a U1 modifier.

TARGETED CASE MANAGEMENT SERVICES

There are two types of Medicaid-funded case management services for Auxiliary Grant residents in ALFs:

1. Twelve-month reassessment only; or
2. Ongoing targeted ALF case management.

It is believed that most of the Auxiliary Grant residents of ALFs will only need the required twelve-month reassessment and not ongoing-targeted case management services. Ongoing Medicaid-Funded Targeted ALF Case Management is a service provided to those Auxiliary Grant residents who are receiving residential or assisted living services and who:

1. Require coordination of multiple services, or have some problem which must be addressed to ensure the resident's health and welfare, or both; and
2. Are not able and do not have other support available to assist in coordination of and access to services or problem resolution; and
3. Need a level of coordination that is beyond what the ALF can reasonably be expected to provide.

The assessor must authorize and arrange for case management services through a qualified case manager if such services are determined to be needed. It is the responsibility of the ALF to determine whether or not they are capable of providing the required coordination of services. Based upon information obtained from staff of the ALF where an individual may be placed, the entity completing the initial and/or 12 month reassessment must determine whether the ALF can meet the care needs and whether ongoing case management is needed. The individual selects a case management agency of his or her choice in the area where he or she will reside.

The CPT/HCPCS procedure code (Locator 24D) on the CMS-1500 (12-90) invoice to bill DMAS for targeted case management services is T2022. These services may only be billed once per quarter per recipient.

MEDICAID BILLING INVOICES

The billing invoice for assisted living services is the CMS-1500 (12-90). (See "Exhibits" at the end of the chapter for a sample of this form).

ADMISSION CERTIFICATION AND PAYMENT PROCESSING

Providers of publicly funded assisted living services must have written authorization from DMAS in order to bill the regular Assisted Living (RAL, authorization #12 on the Long-Term Care Preadmission Screening Authorization form [DMAS-96]) and Intensive Assisted Living (IAL, authorization #13 on the Long-Term Care Preadmission Screening Authorization form [DMAS-96]). Each assisted living facility must have a computer-generated "permission to bill" letter for each assisted living recipient for whom DMAS has been or will be billed for services. Claims submitted for individuals who have not been properly enrolled will be denied. Refer to Chapter VI for detailed information related to the admission certification/recipient enrollment process.

Admission certification packages must be completed for all individuals for whom the ALF is billing DMAS for assisted living services, even if an individual has been subsequently discharged from the service. The ALF must ensure that the screening packet forms are complete and accurate and that the recipient is approved for Auxiliary Grant funds and enrolled in the appropriate program designation. Submission of incomplete or inaccurate documents will result in a delay in the certification process and a subsequent delay in or denial of payment for services.

SUBMISSION OF BILLING INVOICES

Providers must submit claims using the actual dates of service rendered within a calendar month. Providers may only bill for services once per month. Invoices must include only allowable charges for the number of days of services rendered during the calendar month. Any charges submitted **prior** to the date authorized by the assessor as the begin date will be rejected. The provider copy of the invoice must be retained by the provider for record-keeping. All invoices must be mailed with proper postage; messenger or hand deliveries will not be accepted. Provider agencies should allow at least 30 days for claims processing.

Submit billing invoices for Auxiliary Grant residents to:

Department of Medical Assistance Services
Practitioner
P.O. Box 27444
Richmond, Virginia 23261-7444

Except for General Relief residents and MR Waiver recipients noted below, invoices and adjustments should never be mailed to the Department of Medical Assistance Services address; this will only delay processing.

Submit billing invoices for General Relief residents to:

Facility and Home Based Services Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Upon receipt of the "permission to bill" letter for assisted living individuals who are also receiving services through the MR waiver, **submit billing invoices for residents receiving MR waiver services to:**

Facility and Home Based Services Supervisor
RAL/MR Claims
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

ELECTRONIC SUBMISSION OF CLAIMS

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered in to the claims processing system directly. For more information contact our fiscal agent, First Health Services Corporation:

Phone: (800) 924-6741
Fax number: (804) 273-6797

First Health's website: http://virginia.fhsc.com
E-mail: edivmap@fhsc.com

Mailing Address

EDI Coordinator-Virginia Operations
First Health Services Corporation
4300 Cox Road
Richmond, Virginia 23060

TIMELY FILING OF THE CMS-1500 (12-90) FOR ASSISTED LIVING SERVICES

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the date of the last date of service or

discharge. Federal financial participation is not available for claims which **are not** submitted within 12 months from the date of the service. The DMAS-3 form is to be used by electronic billers for attachments (See Exhibits). Medicaid is not authorized to make payment on these late claims, except under the following conditions:

- **Retroactive eligibility** – Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely manner, billing will be handled in the same manner as for delayed eligibility.

- **Delayed Eligibility** – Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for a recipient whose eligibility has been delayed. When the provider did not have knowledge of the Medicaid eligibility of the person prior to rendering the care or service, he or she has 12 months from the date he or she is notified of the Medicaid eligibility in which to file the claim. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local department of social services which specifies that the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted.

The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the receipt of the notification of the delayed eligibility. A copy of the letter from the local department of social services indicating the delayed claim information must be attached to the claim. On the CMS-1500 (12-90) form, enter "ATTACHMENT" in Locator 10d and indicate "Unusual Service" by entering Procedure Modifier "22" in Locator 24D.

Denied Claims – Denied claims submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:

- Complete the CMS-1500 (12-90) invoice as explained under the "Instructions for the Use of the CMS-1500 (12-90) Billing Form" elsewhere in this chapter.

- **Attach** written documentation to verify the explanation. This documentation may be photocopies of invoices or denials by Medicaid or any follow-up correspondence from Medicaid showing that the claim was submitted to Medicaid initially within the required 12-month period.

- Indicate Unusual Service by entering "22" in Locator 24D of the CMS-1500 (12-90) claim form.

Submit the claim in the usual manner using the preprinted envelopes supplied by Medicaid or by mailing the claim to:

Department of Medical Assistance Services
Practitioner
P. O. box 27444
Richmond, Virginia 23261-7444

- Submit the original copy of the claim form to Medicaid. Retain a copy for record keeping. All invoices must be mailed; proper postage is the responsibility of the provider and will help prevent mishandling. Envelopes with insufficient postage will be returned to the provider. **Messenger or hand deliveries will not be accepted.**

- **Accident Cases** – The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired.

- **Other Primary Insurance** - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service.** If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

The procedures for the submission of these claims are the same as previously outlined. The required documentation must be written confirmation that the reason for the delay meets one of the specified criteria.

PREAUTHORIZED SERVICES FOR RETROACTIVE ELIGIBILITY

For services requiring preauthorization, all preauthorization criteria must be met for the claim to be paid. For those services occurring in a retroactive eligibility period, after-the-fact authorizations will be performed by DMAS.

REPLENISHMENT OF BILLING MATERIALS

The CMS-1500 (12-90) Health Insurance Claim Form is a universally accepted claim form that is required when billing DMAS for covered services. The form is available from forms printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 51250-7954

The CMS-1500 (12-90) claim form will not be provided by DMAS

As a general rule, DMAS will no longer provide a supply of agency forms which can be downloaded from the DMAS website (www.dmas.virginia.gov) (***please note the new website address***). To access the forms, click on the "Search Forms" function on the left-hand side of the DMAS home page and select "provider" to access provider forms. Then you may either search by form name or number. If you do not have Internet access, you may request a form for copying by calling the DMAS form order desk at 1-804-780-0076.

For any requests for information or questions concerning the ordering of forms, call 1-(804)-780-0076.

REMITTANCE/PAYMENT VOUCHER

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a record of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The remittance voucher includes an address location which contains the provider's name and current mailing address as shown in the DMAS' provider enrollment file. In the event of a change-of-address, the U.S. Postal Service **will not** forward Virginia Medicaid payment checks and vouchers to another address. Therefore, it is recommended that DMAS' Provider Enrollment and Certification Unit be notified in sufficient time prior to a change-of-address in order for the provider files to be updated.

Providers are encouraged to monitor the remittance vouchers for special messages since they serve as notifications of matters of concern, interest and information. For example, such messages may relate to upcoming changes to Virginia Medicaid policies and procedures; may serve as clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

ANSI X12N 835 HEALTH CARE CLAIM PAYMENT ADVICE

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The 835 Claims Payment Advice transaction set is used to communicate the results of claim adjudication. DMAS will make a payment with an electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is electronically posted to the provider's accounts receivable using the 835. In addition to the 835, the provider will receive an unsolicited 277 Claims Status

Response for the notification of pending claims. For technical assistance with certification of the 835 Claim Payment Advice please contact our fiscal agent, First Health Services Corporation, at (800) 924-6741.

CLAIM INQUIRIES

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Telephone Numbers:

1-804-786-6273	Richmond Area and out-of-state long distance
1-800-552-8627	In-state long distance (toll-free)

Enrollee verification and claim status may be obtained by telephoning:

1-800- 772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

Enrollee verification and claim status may also be obtained by using the Web-based Automated Response System. See Chapter I for more information.

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation. Accordingly, National Standard Formats (NSF) for electronic claims submissions will not be accepted after December 31, 2003, and all local service codes will no longer be accepted for claims with dates of service after December 31, 2003. All claims submitted with dates of service after December 31, 2003, will be denied if local codes are used.

DMAS will accept the National Standard Formats (NSF) for electronic claims submitted on or before December 31, 2003. On June 20, 2003, EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1 (HIPAA-mandated) will also be accepted. Beginning with electronic claims submitted on or after January 1, 2004, DMAS will only accept HIPAA-mandated EDI transactions (claims in National Standard Formats will no longer be accepted). National Codes that replace Local Codes will be accepted for claims with dates of service on or after June 20, 2003. National Codes become mandatory for claims with dates of service on or after January 1, 2004.

The transactions for hospital claims include:

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated (paid and denied) claims
- 270 & 271 for eligibility inquiry and response
- 278 for prior authorization request and response
- Unsolicited 277 for reporting information on pended claims

Information on these transactions can be obtained from our fiscal agent's website: http://virginia.fhsc.com.

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

CLAIMCHECK

ClaimCheck is a fully automated auditing system that verifies the clinical accuracy of claims submitted and reimbursed. DMAS uses ClaimCheck as a post-payment review of professional and laboratory claims. As a result of this auditing process, DMAS makes the necessary voids or adjustment of the claim(s).

INSTRUCTIONS FOR THE USE OF THE CMS-1500 (12-90) BILLING FORM

To bill for services, the Health Insurance Claim Form, CMS-1500 (12-90), invoice form must be used. The following instructions have numbered items corresponding to fields on the CMS-1500. **The required fields to be completed are printed in boldface. Where more specific information is required in these fields, the necessary information is referenced in the locator requiring the information and provider-specific instructions are found at the end of this chapter.**

The purpose of the CMS-1500 is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid recipients. (See "Exhibits" at the end of this chapter for a sample of this form).

Locator		Instructions
1	**REQUIRED**	**ENTER AN "X" IN THE MEDICAID BOX.**
1A	**REQUIRED**	**Insider's I.D. Number – Enter the 12-digit Virginia Medicaid Identification number for the recipient receiving the service.**
2	**REQUIRED**	**PATIENT'S NAME – ENTER THE NAME OF THE RECIPIENT RECEIVING THE SERVICE.**
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insider's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insider's address
8	NOT REQUIRED	Patient Status
9	NOT REQUIRED	Other Insider's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Other Insured's Date of Birth and Sex
9c	NOT REQUIRED	EMPLOYER'S NAME OR SCHOOL NAME
9d	NOT REQUIRED	Insurance Plan Name or Program Name
10	**CONDITIONAL**	**Is Patient's Condition Related To: - Enter an "X" in the appropriate box. (The "place" is not required.)**

Locator		Instructions
		a. Employment? b. Auto Accident? c. Other Accident? (This includes schools, stores, assults, etc.)
10d	**CONDITIONAL**	**Enter "ATTACHMENT" if documents are attached to the claim form or if procedure modifier "22" (unusual services) is used.**
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Employer's Name or School Name
11c	NOT REQUIRED	Insurance Plan or Program Name
11d	NOT REQUIRED	Is There Another Health Benefit Plan?
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	NOT REQUIRED	Date of Current Illness, Injury, or Pregnancy (Date care began, located on the DMAS-93 form)
15	NOT REQUIRED	If Patient Has Had Same or Similar Illness
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	NOT REQUIRED	Name of Referring Physician or Other Source
17a	NOT REQUIRED	I.D. Number of Referring Physician – Enter the Virginia Medicaid number of the referring physician. See the following pages for special instructions for your services.
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	**CONDITIONAL**	CLIA#
20	NOT REQUIRED	Outside Lab?
21	NOT REQUIRED	Diagnosis or Nature of Illness or Injury – Enter the appropriate ICD-9CM diagnosis which describes the nature of the illness or injury for which the service was rendered.
22	**CONDITIONAL**	**Medicaid Resubmission – Required for adjustment**

Locator		Instructions
		and void. See the instructions for Adjustment and Void Invoices.
23	**CONDITIONAL**	**Prior Authorization Number - Enter the PA number for the approved service.**
24A	**REQUIRED**	**Dates of Service – Enter the from and thru dates in a 2-digit format for the month, day, and year (e.g., 03/01/00). DATES MUST BE WITHIN THE SAME CALENDAR MONTH.**
24B	**REQUIRED**	**Place of Service – Enter the 2-digit National Place of Service code which describes where the services were rendered.**
24C	**REQUIRED**	**Type of Service – Enter the one-digit National code for the type of service rendered.**
24D	**REQUIRED**	**Procedures, Services or Supplies** **CPT/HCPCS – Enter the 5-character CPT/HCPCS code which describes the service provided**. **T1020 Regular Assisted Living Services** **T1020 U1 Intensive Assisted Living Services** **T2022 Targeted Case Management Services** **MODIFIER – Enter the appropriate CPT/HCPCS modifier(s) if applicable. NOTE: Use modifier "22" for individual consideration. Claims will pend for manual review of attached documentation.** **22 Unusual service (i.e., over one-year old claims, with attached explanation)**
24E	NOT REQUIRED	Diagnosis Code – Enter the entry identifier of the ICD-9CM diagnosis code listed in Locator 21 as the primary diagnosis. NOTE: Only one code is processable.
24F	**REQUIRED**	**Charges – Enter your total usual and customary charges for the procedure/services. See the special instructions following these instructions if applicable for your service.**
24G	**REQUIRED**	**Days or Unit – Enter the number of times the service was provided during the service period. See the pages following the instructions for special instructions if**

Locator		Instructions
		applicable to your service.
24H	NOT REQUIRED	EPSDT or Family Planning – Enter the appropriate indicator. Required only for EPSDT or family planning services. 1 - Early and Periodic Screening, Diagnosis, and Treatment Program Services 2 - Family Planning Service
24I	**CONDITIONAL** **REQUIRED**	**EMG (Emergency) – Place a "1" in this block if the services are emergency-related. Leave blank if not an emergency.**
24J		**COB (Primary Carrier Information) – Enter the appropriate code. See special instructions if required for your service.** **2 – No Other Carrier** **3 - Billed and Paid** **5 - Billed, No Coverage**
24K	**REQUIRED**	**Reserved for Local Use – Enter the dollar amount received from the primary carrier if block 24J is coded "3." See special instructions if required for your service.**
25	NOT REQUIRED	Federal Tax I.D. Number
26	OPTIONAL	Patient's Account Number – Up to seventeen alphanumeric characters are acceptable.
27	NOT REQUIRED	Accept Assignment
28	NOT REQUIRED	Total Charge
29	NOT REQUIRED	Amount Paid
30	NOT REQUIRED	Balance Due
31	**REQUIRED**	**Signature of Physician or Supplier Including Degrees or Credentials – The provider or agent must sign and date the invoice in this block.**

Locator		Instructions
32	NOT REQUIRED	Name and Address of Facility Where Services Were Rendered
33	**REQUIRED**	**Physician's, Supplier's Billing Name, Address ZIP Code & Phone # - Enter the provider's billing name, address, ZIP Code, and phone number as they appear in your Virginia Medicaid provider record. Enter your Virginia Medicaid provider number (servicing provider) in the PIN # field. Ensure that your provider number is distinct and separate from your phone number or ZIP Code. Enter Group# (billing provider number) if applicable.**

LOCAL TO NATIONAL CODE CROSSWALK

Below is a listing of the old local codes that are replaced with the new national codes as required by HIPAA. Local codes will be accepted for claims with dates of service through December 31, 2003. National codes are optional for claims with dates of service before on or December 31, 2003, but are mandatory for claims with dates of service on or after January 1, 2004.

Old Code	New Code		Modifier
Z8574	T2022	Targeted Case Management Services	(None)
Z8575	T1020	Regular Assisted Living Services	(None)
Z8576	T1020	Intensive Assisted Living Services	U1

NOTE: T1020 must have a U1 modifer in order to receive the higher reimbursement rate.

Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (12-90), as an Adjustment Invoice

The Adjustment Invoice is used to change information on a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (12-90), except for the locator indicated below.

Locator 22 **Medicaid Resubmission**

Code – Enter the 4-digit code identifying the reason for the submission of the adjustment invoice.

1023 Primary Carrier has made additional payment
1024 Primary Carrier has denied payment
1025 Accommodation charge correction
1026 Patient payment amount changed
1027 Correcting service periods
1028 Correcting procedure/service code
1029 Correcting diagnosis code
1030 Correcting charges
1031 Correcting units/visits/studies/procedures
1032 IC reconsideration of allowance, documented
1033 Correcting admitting, referring, prescribing, provider identification number
1053 Adjustment reason is in the Misc. Category

Original Reference Number/ICN – Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each CMS-1500 submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim).

Instructions for the Completion of the Health Insurance Claim Form CMS-1500 (12-90), as a Void Invoice

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Clam Form, CMS-1500 (12-90), except for the locator indicated below.

Locator 22 **Medicaid Resubmission**

Code – Enter the 4-digit code identifying the reason for the submission of the void invoice.

1042 Original claim has multiple incorrect items
1044 Wrong provider identification number
1045 Wrong recipient eligibility number
1046 Primary carrier has paid DMAS maximum allowance
1047 Duplicate payment was made
1048 Primary carrier has paid full charge
1051 Recipient not my patient
1052 Void is for miscellaneous reasons
1060 Other insurance is available

Original Reference Number/ICN – Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each CMS-1500 submitted as a Void Invoice. (Each line under Locator 24 is one claim).

SPECIAL BILLING INSTRUCTIONS
CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM

The primary care physician (PCP) and any other provider who is part of the PCP'S CMM Affiliation Group bills for services in the usual manner, but other physicians must follow special billing instructions to receive payment. (Affiliation Groups are explained in Chapter I under CMM). Other physicians must indicate a PCP referral or an emergency unless the service is excluded from the requirement for a referral. Excluded services are listed in Chapter I.

All services should be coordinated with the primary health care provider whose name is provided at the time of verification of eligibility. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

When treating a restricted enrollee, a physician covering for the primary care physician or on referral from the primary care physician must place the primary care physician's Medicaid provider number in Locator 17a and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice.

In a medical emergency situation, if the practitioner rendering treatment is not the primary care physician, he or she must certify that a medical emergency exists for payment to be made. The provider must enter a "1" in Locator 24I and attach an explanation of the nature of the emergency.

LOCATOR	SPECIAL INSTRUCTIONS
10d	Write "ATTACHMENT" for the Practitioner Referral Form, DMAS-70, or for remarks as appropriate.
17a	When a restricted enrollee is treated on referral from the primary physician, enter the primary physician's Medicaid provider number (as indicated on the DMAS-70 referral form) and attach a copy of the Practitioner Referral Form to the invoice. Write "ATTACHMENT" in Locator 10d.
24I	When a restricted enrollee is treated in an emergency situation by a provider other than the primary physician, the non-designated physician enters a "1" in this Locator and explains the nature of the emergency in an attachment. Write "ATTACHMENT" in Locator 10d.

EDI Billing (Electronic Claims)

Follow the instructions for the 837 transaction and the standard for attachments using the Claim Attachment Form (DMAS-3).

INVOICE PROCESSING

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a cross reference number, and entered into the system, it is placed in one of the following categories:

TURNAROUND DOCUMENT LETTER (TAD)

If lines on an invoice are completed improperly, a computer-generated letter (TAD) is sent to the provider to correct the error. The TAD should be returned to First Health. The claim will be denied if the TAD is not received in the system within 21 days. Only requested information should be returned. Additional information will not be considered and may cause the claim to deny in error.

- Remittance Voucher
    - **Approved** - Payment is approved or placed in a pended status for manual adjudication (the provider must not resubmit).
    - **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.
- No Response - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form. **The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.**

EXHIBITS

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PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

HEALTH INSURANCE CLAIM FORM

PICA ☐☐☐ PICA ☐☐☐

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CLAIM ATTACHMENT FORM

Attachment Control Number (ACN) :

Patient Account Number (20 positions limit)* **M M D D C C Y Y** **Sequence Number (5 digits)**

Date of Service

***Patient Account Number should consist of numbers and letters only. NO spaces, dashes, slashes or special characters.**

Provider Number:	**Provider Name:**

Enrollee Identification Number:

Enrollee Last Name:	**First:**	**MI:**

☐ **Paper Attached** ☐ **Photo(s) Attached** ☐ **X-Ray(s) Attached**

☐ **Other (specify)**_____

COMMENTS:_____

_____

_____

_____

_____

_____

THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE. ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

Authorized Signature _____ **Date Signed** _____

Mailing addresses are available in the Provider manuals or check DMAS website at www.dmas.virginia.gov. Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number.

INSTRUCTIONS FOR THE COMPLETION OF THE DMAS-3 FORM. THE DMAS-3 FORM IS TO BE USED BY EDI BILLERS ONLY TO SUBMIT A NON-ELECTRONIC ATTACHMENT TO AN ELECTRONIC CLAIM.

Attachment Control Number (ACN) should be indicated on the electronic claim submitted. The ACN is the combined fields 1, 2 and 3 below. (i.e. Patient Account number is 123456789. Date of service is 07/01/2003. Sequence number is 12345. The ACN entered on the claim should be 12345678907012003 12345).

IMPORTANT: THE ACN ON THE DMAS-3 FORM MUST MATCH THE ACN ON THE CLAIM OR THE ATTACHMENT WILL NOT MATCH THE CLAIM SUBMITTED. IF NO MATCH IS FOUND, CLAIM MAY BE DENIED. ATTACHMENTS MUST BE SUBMITTED AND ENTERED INTO THE SYSTEM WITHIN 21 DAYS OR THE CLAIM MAY RESULT IN A DENIAL.

1. **Patient Account Number** – Enter the patient account number up to 20 digits. Numbers and letters only should be entered in this field. **Do not** enter spaces, dashes or slashes or any special characters.

2. **Date of Service** – Enter the from date of service the attachment applies to.

3. **Sequence Number** –Enter the provider generated sequence number up to 5 digits only.

4. **Provider Number** – Enter the Medicaid Provider number.

5. **Provider Name** – Enter the name of the Provider.

6. **Enrollee Identification Number** – Enter the Medicaid ID number of the Enrollee.

7. **Enrollee Last Name** - Enter the last name of the Enrollee.

8. **First** – Enter the first name of the Enrollee.

9. **MI –** Enter the middle initial of the Enrollee.

10. **Type of Attachment –** Check the type of attachment or specify.

11. **Comment –** Enter comments if necessary.

12. **Authorized Signature –** Signature of the Provider or authorized Agent.

13. **Date Signed** – Enter the date the form was signed.

Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number. Mailing addresses are available in the Provider manuals or check the DMAS website at www.dmas.virginia.gov.